MDS 3.0 Training
Payment Items and Documentation Requirements

Case Mix Team
February 2021
Mini-Series #1

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MDS 3.0 Training
Payment Items and Documentation

Session #1 Agenda: Payment Items and Documentation

- Welcome and overview
- Introduction to Case Mix
- Section A
- Section B
- Section C
- Section D
- Section E
- Section M
- Questions

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CMS Resources for MDS 3.0

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/index.html

RAI Manual: click on RAI manual on left, scroll down to bottom of page.

Item Set (MDS 3.0 Assessment tool): click on RAI technical information on left; scroll down to bottom of page.

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MaineCare Case Mix

Maine uses a modified RUG III Code for Case Mix purposes.

PPS / Medicare uses PDPM HIPPS codes

Supporting Documentation for Case Mix payment items is required

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Case Mix Quality Assurance Review

About every 6 months, a Case Mix nurse reviews a sample of MDS 3.0 assessments and resident records to check the accuracy of the MDS 3.0 assessments.

Insufficient, inaccurate or lack of documentation to support information coded on the MDS 3.0 may lead to an error.

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Poor Documentation could also mean…

Lower payment than the facility could be receiving,

OR

Overpayment which could lead to re-payment to the State (Sanctions). This is due to either overstating the care a resident received or insufficient documentation to support the care that was coded.

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Sanctions:

2%	Error rate 34% or greater and less than 37%
5%	Error rate 37% or greater and less than 41%
7%	Error rate 41% or greater and less than 45%
10%	Error rate 45% or greater
10%	If requested reassessments not completed within 7 days

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MaineCare Case Mix
Documentation

- Resident interviews will be accepted as coded on the MDS 3.0—NO additional supporting documentation is required.
- Staff interviews **must be documented** in the resident's record. If interviews are summarized in a narrative note, the interviewer must document the **date** of the interview, **name of staff** interviewed, and staff **responses** to scripted questions asked.
- Follow all "Steps for Assessment" in the RAI Manual, for the interview items.

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Visit the portal at:
https://www.maine.gov/dhhs/dlc/licensing-certification/medical-facilities/minimum-data-set-training

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Long Term Care Facility
Resident Assessment Instrument (RAI)
User's Manual

Chapter 3

Effective Oct 2019

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Section A

Intent: The intent of this section is to obtain key information to uniquely identify each resident, the home in which he or she resides, and the reasons for assessment.

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Section A
A0310 Purpose

Documents the reason for completing the assessment

Identifies the item set required based on the type of assessment being completed

There are several subsections to A0310

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Section A
A0310A Federal OBRA Reason for Assessment

01. Admission
02. Quarterly
03. Annual
04. Significant change in status
05. Significant correction to prior comprehensive
06. Significant correction to prior quarterly
99. Not OBRA required

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Significant Change Criteria

A **"significant change"** is a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, is not "self-limiting" (for declines only);
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

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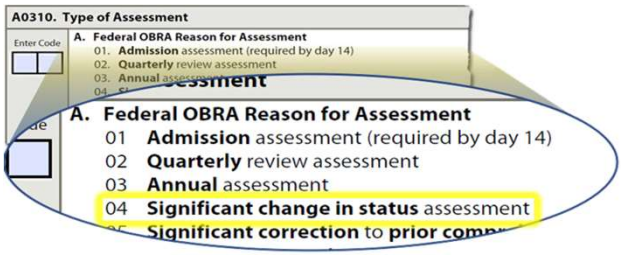
A0310A Hospice Benefit

- Electing or revoking the hospice benefit requires a significant change in status assessment



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Assessment Scheduling

Assessment Type/Item Set	MDS Assessment Code (A0310A or A0310F)	Assessment Reference Date (ARD) (Item A2300) No Later Than	7-day Observation Period (Look Back) Consists Of	14-day Observation Period (Look Back) Consists Of	MDS Completion Date (Item Z0500B) No Later Than	CAA(s) Completion Date (Item V0200B2) No Later Than	Care Plan Completion Date (Item V0200C2) No Later Than	Transmission Date No Later Than	Regulatory Requirement	Assessment Combination
Admission (Comprehensive)	A0310A= 01	14th calendar day of the resident's admission (admission date + 13 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day of the resident's admission (admission date + 13 calendar days)	14th calendar day of the resident's admission (admission date + 13 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (Initial) 42 CFR 483.20 (b)(2)(i) (by the 14th day)	May be combined with any OBRA assessment; 5- and 14-day PPS; or Part A PPS Discharge assessment
Annual (Comprehensive)	A0310A= 03	ARD of previous OBRA comprehensive assessment + 366 calendar days AND ARD of previous OBRA Quarterly assessment + 92 calendar days	ARD + 6 previous calendar days	ARD +13 previous calendar days	ARD + 14 calendar days	ARD + 14 calendar days	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(iii) (every 12 months)	May be combined with any OBRA or PPS assessment
Significant Change in Status (SCSA) (Comprehensive)	A0310A= 04	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	ARD + 6 previous calendar days	ARD + 13 previous calendar days	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	14th calendar day after determination that significant change in resident's status occurred (determination date + 14 calendar days)	CAA(s) Completion Date + 7 calendar days	Care Plan Completion Date + 14 calendar days	42 CFR 483.20 (b)(2)(ii) (within 14 days)	May be combined with any OBRA or PPS assessment

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Section A
A2300 Assessment Reference Date (ARD)

- Designates the **end** of the look-back period so that all assessment items refer to the resident's status during the same period of time.
- Anything that happens after the ARD will not be captured on that MDS.
- The look-back period includes observations and events through the end of the day (midnight) of the ARD.

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Section B
Hearing, Speech, and Vision

Intent: The intent of items in this section is to document the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others and whether the resident experiences visual limitations or difficulties related to diseases common in aged persons.

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Section B

B0100: **Comatose**
B0200: Ability to Hear (with hearing aid if normally used)
B0300: Hearing Aid
B0600: Speech Clarity
B0700: **Makes Self Understood**
B0800: Ability to Understand Others
B1000: Vision (with adequate light)
B1200: Corrective Lenses

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Section B

B0700, page B-7: 4. Consult with the primary nurse assistants (over all shifts), and the resident's family, and speech-language pathologist.

Coding Tips and Special Populations

- *This item cannot be coded as Rarely/Never Understood if the resident completed any of the resident interviews*, as the interviews are conducted during the look-back period for this item and should be factored in when determining the residents' ability to make self understood during the entire 7-day look-back period.

- While B0700 and the resident interview items are not directly dependent upon one another, inconsistencies in coding among these items should be evaluated.

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Section C
Cognitive Patterns

Intent: The items in this section are intended to determine the resident's attention, orientation and ability to register and recall new information. These items are crucial factors in many care-planning decisions.

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Section C

Steps for Assessment

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.
2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700–C1000, Staff Assessment of Mental Status.
3. Review Language item (A1100), to determine if the resident needs or wants an interpreter.

• If the resident needs or wants an interpreter, complete the interview with an interpreter.

Coding Instructions

Code 0, **no**: if the interview should not be conducted because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed but not available.

Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

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Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of the ARD), item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done.
- Because a PDPM cognitive level is utilized in the speech language pathology (SLP) payment component of PDPM, **only** in the case of PPS assessments, staff may complete the Staff Assessment for Mental Status for an interviewable resident when the resident is unexpectedly discharged from a Part A stay prior to the completion of the BIMS. In this case, the assessor should enter 0, No in C0100: Should Brief Interview for Mental Status Be Conducted? and proceed to the Staff Assessment for Mental Status.

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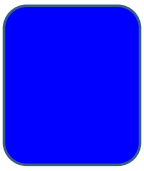
Section C

C0200-C0500: BIMS resident interview questions (scripted interview)

Sock



Blue

Bed

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Section C

C0600: Should the *staff* assessment be conducted?

C0700-C1000 Staff assessment:

C0700 Short-Term Memory

C0800 Long-Term Memory

C0900 Memory/Recall Ability

C1000 Cognitive Skills for Daily Decision Making

Documentation required to confirm responses

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Section D
Mood

Intent: The items in this section address mood distress, a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity. It is particularly important to identify signs and symptoms of mood distress among nursing home residents because these signs and symptoms can be treatable.

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Section D

D0100: Should Resident Mood Interview Be Conducted?

If yes…

D0200 (Resident Interview – PHQ9©)

Enter the frequency of symptoms for Column 2, Items A through I

Requires no further supporting documentation. Case mix nurses check for *timely completion* according to Z0400.

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MDS 3.0 Changes
Payment Items and Documentation

Section D

Steps for Assessment:

1. Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards.

2. Determine whether the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to D0500, Staff Assessment of Resident Mood (PHQ-9-OV©).

Coding Instructions:

Code 0, **no**: if the interview should not be *conducted* because the resident is rarely/never understood; cannot respond verbally, in writing, or using another method; or an interpreter is needed, but not available.

Code 1, yes: if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available.

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MDS 3.0 Changes Effective 10/1/18

Section D

Coding Tips

- Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood.
- If the resident interview was not conducted within the look-back period (preferably the day before or the day of)the ARD, item D0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items.
- Do not complete the Staff Assessment for Resident Mood items (D0500) if the resident interview should have been conducted, but was not done.

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Section D D0200

D0200. Resident Mood Interview (PHQ-9©)

Say to resident: "*Over the last 2 weeks, have you been bothered by any of the following problems?*"

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
If yes in column 1, then ask the resident: "*About **how often** have you been bothered by this?*"
Read and show the resident a card with the symptom frequency choices. Indicate response in column 2, Symptom Frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)
   9. **No response** (leave column 2 blank)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. *Little interest or pleasure in doing things*	CATs	RUG III PDPM
B. *Feeling down, depressed, or hopeless*		RUG III PDPM
C. *Trouble falling or staying asleep, or sleeping too much*		RUG III PDPM
D. *Feeling tired or having little energy*		RUG III PDPM
E. *Poor appetite or overeating*		RUG III PDPM
F. *Feeling bad about yourself - or that you are a failure or have let yourself or your family down*		RUG III PDPM
G. *Trouble concentrating on things, such as reading the newspaper or watching television*		RUG III PDPM
H. *Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual*		RUG III PDPM
I. *Thoughts that you would be better off dead, or of hurting yourself in some way*	CATs	RUG III PDPM

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Section D
D0300

D0300 Total Severity Score

A summary of the frequency scores that indicates the extent of potential depression symptoms. The score does not diagnose a mood disorder, but provides a standard of communication with clinicians and mental health specialists.

Total score must be between 00 and 27

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Section D
D0500

Staff Assessment of Resident Mood - PHQ-9-OV (observational version)

Look-back period for this item is 14 days.

- Interview staff from all shifts who know the resident best.
- Encourage staff to report symptom frequency, even if the staff believes the symptom to be unrelated to depression.

Supporting documentation is required

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D0500. Staff Assessment of Resident Mood (PHQ-9-OV*)
Do not conduct if Resident Mood Interview (D0200-D0300) was completed

Over the last 2 weeks, did the resident have any of the following problems or behaviors?

If symptom is present, enter 1 (yes) in column 1, Symptom Presence.
Then move to column 2, Symptom Frequency, and indicate symptom frequency.

1. **Symptom Presence**
   0. **No** (enter 0 in column 2)
   1. **Yes** (enter 0-3 in column 2)

2. **Symptom Frequency**
   0. **Never or 1 day**
   1. **2-6 days** (several days)
   2. **7-11 days** (half or more of the days)
   3. **12-14 days** (nearly every day)

	1. Symptom Presence	2. Symptom Frequency
	↓ Enter Scores in Boxes ↓	
A. Little interest or pleasure in doing things	CATs	RUG III PDPM
B. Feeling or appearing down, depressed, or hopeless		RUG III PDPM
C. Trouble falling or staying asleep, or sleeping too much		RUG III PDPM
D. Feeling tired or having little energy		RUG III PDPM
E. Poor appetite or overeating		RUG III PDPM
F. Indicating that s/he feels bad about self, is a failure, or has let self or family down		RUG III PDPM
G. Trouble concentrating on things, such as reading the newspaper or watching television		RUG III PDPM
H. Moving or speaking so slowly that other people have noticed. Or the opposite - being so fidgety or restless that s/he has been moving around a lot more than usual		RUG III PDPM
I. States that life isn't worth living, wishes for death, or attempts to harm self	CATs	RUG III PDPM
J. Being short-tempered, easily annoyed		RUG III PDPM

D0600. Total Severity Score

Enter Score

Add scores for all frequency responses in Column 2, Symptom Frequency. Total score must be between 00 and 30. CATs RUG III PDPM

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Section E
Behavior

Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis.

This section focuses on the resident's actions, not the intent of his or her behavior. Because of their interactions with residents, staff may have become used to the behavior and may underreport or minimize the resident's behavior by presuming intent.

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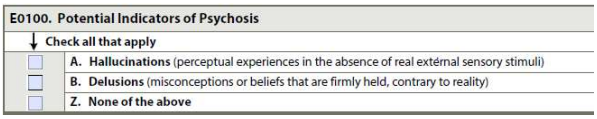
BEHAVIORAL SYMPTOMS

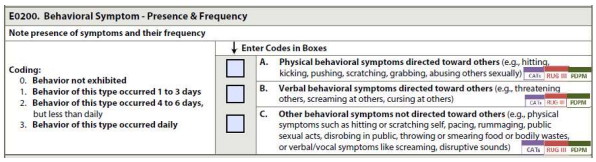
Payment Items

E0100A Hallucinations
E0100B Delusions



E0100. Potential Indicators of Psychosis	
↓ Check all that apply	
☐	A. **Hallucinations** (perceptual experiences in the absence of real external sensory stimuli)
☐	B. **Delusions** (misconceptions or beliefs that are firmly held, contrary to reality)
☐	Z. **None of the above**

E0200A Physical behaviors
E0200B Verbal behaviors
E0200C Other behaviors



E0200. Behavioral Symptom - Presence & Frequency		
Note presence of symptoms and their frequency		
Coding: 0. Behavior not exhibited 1. Behavior of this type occurred 1 to 3 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily	↓ Enter Codes in Boxes	
	☐	A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) CATs RUG III PDPM
	☐	B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) CATs RUG III PDPM
	☐	C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) CATs RUG III PDPM

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Section E: E0200

E0200. Behavioral Symptom - Presence & Frequency		
Note presence of symptoms and their frequency		
Coding: 0. **Behavior not exhibited** 1. **Behavior of this type occurred 1 to 3 days** 2. **Behavior of this type occurred 4 to 6 days,** but less than daily 3. **Behavior of this type occurred daily**	↓ Enter Codes in Boxes	
	☐	A. **Physical behavioral symptoms directed toward others** (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) CATs RUG III PDPM
	☐	B. **Verbal behavioral symptoms directed toward others** (e.g., threatening others, screaming at others, cursing at others) CATs RUG III PDPM
	☐	C. **Other behavioral symptoms not directed toward others** (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) CATs RUG III PDPM

E0300: Overall Presence of Behavioral Symptoms
E0500: Impact on Resident
E0600: Impact on Others

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Section E: E0800 and E0900

E0800. Rejection of Care - Presence & Frequency

Enter Code ☐

Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) **that is necessary to achieve the resident's goals for health and well-being?** Do not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and determined to be consistent with resident values, preferences, or goals.

0. **Behavior not exhibited**
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

CATs RUG III PDPM

E0900. Wandering - Presence & Frequency

Enter Code ☐

Has the resident wandered?

0. **Behavior not exhibited** → Skip to E1100, Change in Behavior or Other Symptoms
1. **Behavior of this type occurred 1 to 3 days**
2. **Behavior of this type occurred 4 to 6 days,** but less than daily
3. **Behavior of this type occurred daily**

CATs RUG III PDPM

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Section M
Skin Conditions

Intent: The items in this section document the risk, presence, appearance, and change of pressure ulcers/injuries. This section also notes other skin ulcers, wounds, or lesions, and documents some treatment categories related to skin injury or avoiding injury. It is imperative to determine the etiology of all wounds and lesions, as this will determine and direct the proper treatment and management of the wound.

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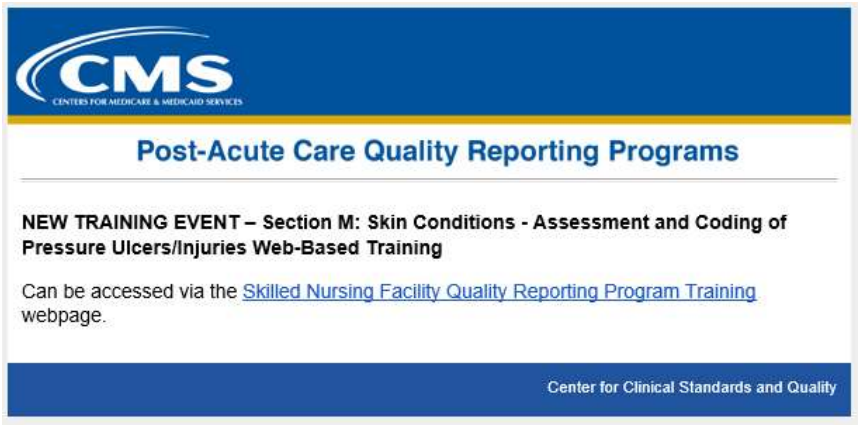

https://pac.training/courses/Section_M/#/

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Section M

DEFINITION:
PRESSURE ULCER/INJURY
A pressure ulcer/injury is localized injury to the skin and/or underlying tissue, usually over a bony prominence, as a result of intense and/or prolonged pressure or pressure in combination with shear. The pressure ulcer/injury can present as intact skin or an open ulcer and may be painful.

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Section M
M0300 Unhealed Pressure Ulcers

M0300A: Number of Stage 1
M0300B: Number of Stage 2
number present on admission
M0300C: Number of Stage 3
number present on admission
M0300D: Number of Stage 4
number present on admission
M0300F: Unstageable Pressure Ulcers Related to Slough and/or Eschar

DEFINITIONS:
EPITHELIAL TISSUE
New skin that is light pink and shiny (even in persons with darkly pigmented skin). In Stage 2 pressure ulcers, epithelial tissue is seen in the center and at the edges of the ulcer. In full thickness Stage 3 and 4 pressure ulcers, epithelial tissue advances from the edges of the wound.

GRANULATION TISSUE
Red tissue with "cobblestone" or bumpy appearance; bleeds easily when injured.

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M1030: Number of Venous and Arterial Ulcers

M1030: Definitions , RAI Manual, page M-26

VENOUS ULCERS: Ulcers caused by peripheral venous disease, which most commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg.

ARTERIAL ULCERS: Ulcers caused by peripheral arterial disease, which commonly occur on the tips and tops of the toes, tops of the foot, or distal to the medial malleolus.

Pressure Ulcers/injuries or vascular ulcers are payment items if 2 or more treatments are required and provided.

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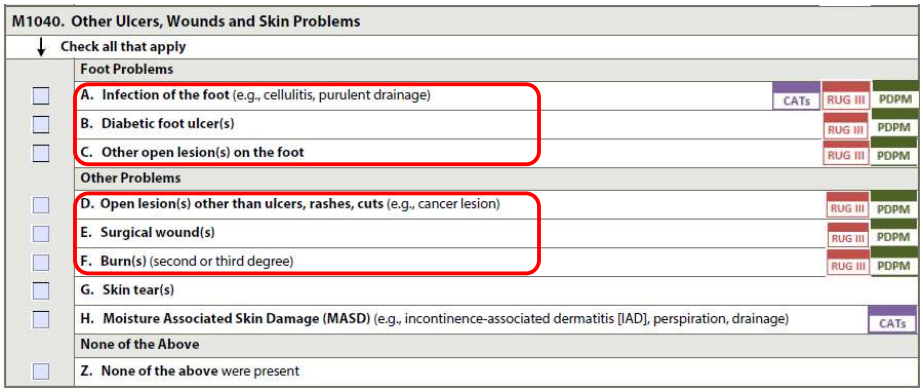
Section M: **M1040 Other Ulcers, Wounds, and Skin Problems**



M1040. Other Ulcers, Wounds and Skin Problems		
↓ Check all that apply		
	Foot Problems	
☐	**A. Infection of the foot** (e.g., cellulitis, purulent drainage)	CATs, RUG III, PDPM
☐	**B. Diabetic foot ulcer(s)**	RUG III, PDPM
☐	**C. Other open lesion(s) on the foot**	RUG III, PDPM
	Other Problems	
☐	**D. Open lesion(s) other than ulcers, rashes, cuts** (e.g., cancer lesion)	RUG III, PDPM
☐	**E. Surgical wound(s)**	RUG III, PDPM
☐	**F. Burn(s)** (second or third degree)	RUG III, PDPM
☐	**G. Skin tear(s)**	
☐	**H. Moisture Associated Skin Damage (MASD)** (e.g., incontinence-associated dermatitis [IAD], perspiration, drainage)	CATs
	None of the Above	
☐	**Z. None of the above** were present	

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M1200 Skin and Ulcer/Injury Treatments

A. Pressure reducing device for chair

B. Pressure reducing device for bed

- do **not** include egg crate cushions of any type, donut or ring devices for chairs

C. Turning/repositioning program

- *Specific* approaches for changing resident's position and re-aligning the body
- *Specific* intervention and frequency
- Requires supporting documentation of monitoring and periodic evaluation

D. Nutrition and hydration

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M1200 Skin and Ulcer/Injury Treatments (continued)

E. Pressure Ulcer Care
F. Surgical Wound Care
G. Non-surgical Dressing (other than feet)
H. Ointments/medications (other than feet)
I. Dressings to feet
Z. None of the above

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MDS 3.0 – The Mini-series
Documentation Guidelines

MDS 3.0 Documentation Requirements
August 2020

MDS 3.0 Item	Item Description	RUG III Categories Description	Documentation Requirement
B0100	Comatose/ Persistent Vegetative State (CPS)	*Clinically Complex Impaired Cognition*	Physician documented diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Does not include residents with advanced stages of progressive neurological disorders. The service plan or care plan must also describe the specific care needs of the resident due to his condition.
B0700	Resident makes self-understood (CPS)	*Impaired Cognition*	Documentation of resident's degree of impairment, ability to express or communicate requests, needs, opinions, and to conduct social conversation in his or her primary language whether in speech, writing, sign language, or a combination, over **all shifts**. This may include reduced voice volume, difficulty producing sounds or difficulty finding the right words, making sentences, writing and/or gesturing. Observations and interviews with family and/or speech pathologist that were used to justify the coding on the MDS must be documented in the medical record.
C0200 – C0500	Resident interview for cognition (BIMS)	*Impaired Cognition*	Validation of completion of items C0200-C0500 at **Z0400** on or before the ARD Date, **OR** Documentation the resident interview of BIMS items was completed *preferably the day before or day of the ARD.*
C0700	Short term memory (CPS)	*Impaired Cognition*	Documentation to determine the resident's short-term memory status by requesting that staff from **each shift**, validate resident's response to an event 5 minutes after it occurred. See RAI Manual, Section C for instructions.
C1000	Cognitive skills for daily decision making	*Impaired Cognition*	*Documentation by direct-care staff across **all shifts** within the 7-day look-back period demonstrating the degree of compromised decision-making about tasks of everyday living, including choosing clothing, knowing when to go to meals, using environmental cues to organize and plan, seeking*

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MDS 3.0 Training
Payment Items and Documentation

Questions?

Forum call for Nursing Facilities
1st Thursday of the month in February, May, August and November, 1:00-2:00

Training sessions for Payment Items and Documentation will be scheduled for March, June, September, and December of each year

Call the MDS Help Desk to register!
- (207) 624-4095 or (toll free) 1-844-288-1612, OR
- MDS3.0.dhhs@maine.gov (email)

To download MDS resources from State of Maine website:

https://www.maine.gov/dhhs/oms/providers/case-mix-private-duty-nursing-and-home-health

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MDS 3.0 Training
Payment Items and Documentation

Reminder!

- This completes *Payment Items and Documentation* of the MDS 3.0 training.
- Ask questions!
- Ask more question!!
- Use your resources (other MDS coordinators, case mix staff, MDS Help Desk, Forum Calls etc.)
- Attend training as often as you need.

Please complete your evaluations to help us to continually improve training to best meet your needs.

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MDS 3.0 – The Mini-series Contact Information:

- **MDS Help Desk**: 624-4095 or toll-free: 1-844-288-1612
  MDS3.0.DHHS@maine.gov
- **Deb Poland, RN**: 215-9675
  Debra.Poland@maine.gov
- **Christina Stadig RN:** 446-3748
  Christina.Stadig@maine.gov
- **Emma Boucher RN, RAC-CT**: 446-2701
  Emma.Boucher@maine.gov
- **Sue Pinette, RN, RAC-CT**: 287-3933 or 215-4504 (cell)
  Suzanne.Pinette@maine.gov

Training Portal: www.maine.gov/dhhs/dlrs/mds/training/

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Questions?

Case Mix Team
Sue Pinette RN, RAC-CT
State RAI Coordinator and Case Mix Manager
207-287-3933

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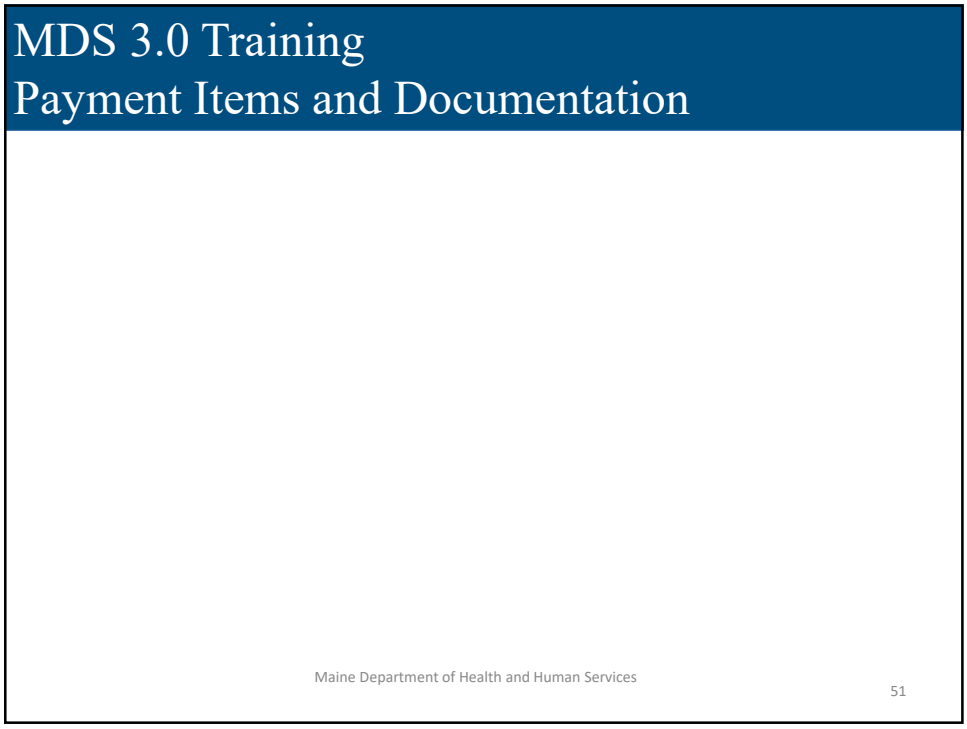
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